

## MANUAL CLAIM FORM VTPART D CLAIM - NCPDP vD.0

Return to: Goold Health Systems, Inc. 1 Greentree Drive, Suite 2

S. Burlington, Vt 05403 Fax Number: 1-844-679-5366

Patient Name		Cardholder ID							Pharmacy Name						NABP								
Street Address	City			Plan Name Patient DOB					Geno	der I	Pharn	narmacy Address					NPI						
Claim 1																							
Comments:				Other Coverage Code				Benefit Stage 01(DE				ED) Benefit Stage 02 (INIT)					Benefit Stage 03(GAP)						
Rx Number	Prescri	ber NPI	#	P	Prescriber 1		Name			Ι	Date Prescribed		ibed	Date F	illed		Quantity		Days' Sup		y		
PA #	MN	ame, St	Strength, Dosage, Mfg.				NDC			PDP Cop			bay Sub		Clar Code			Total Billed					
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Coordination of Benefits (						D D				ODA	D					OD	DD 4						
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2										Qual		Amt	mt Qual		Amt	Qual		Ar		Amt			
Claim 2								•	-				•										
Comments:				Other Coverage Code Be					enefit Stage 01(DED)				Benefit Stage 02 (INIT)				Benefit Stage 03(GAP)						
Rx Number	Ref#	Prescriber NP		#	P	Prescriber 1		Name			D		Date Prescribed		Date Filled			Quanti	ty	Days'	Suppl	y	
PA #	MN Drug Name,			Strength, Dosage, Mfg.				NDC				PDP Cop			av	Sub	Clar Code			Total	Billed		
3			,											•	•								
Coordination of Benefits (	(COB) – O	ther Pay	er Info	rmation				1 1	1 1														
Other Payer ID		Payer D				ejec	ejects OF			AP						OPPRA							
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2										Qual	1	Amt	1	Qual	Amt	Qu	al		An	nt		_	
Provider Signature		I		1		1		Da	ate Si	gned			1			1						_	

Updated: 01/25/16